Exhibit L

Reimbursement

CLINTON PLANS TO REVIVE AVERAGE ACQUISITION COST ISSUE

Durable medical equipment suppliers and home infusion providers that were relieved when Congress decided last year not to reduce payments for prescription drugs to actual acquisition cost may have relaxed too soon.

In a recent radio address, **President Clinton** said he plans to revive the proposal this year.

Calling high premiums paid for drugs "simply unacceptable," Clinton vowed to send Congress the same legislation he sent last year. Congress chose to reduce reimbursement to 95 percent of average wholesale prices, instead of average acquisition costs, which would have eliminated all profit margins and payments for services.

Clinton's comments come on the heels of a report by the **HHS Office of Inspector General** suggesting Medicare could have saved $447 million, or 29 percent, on expenditures for 22 selected drugs by paying actual acquisition cost instead of average wholesale price. If these figures are extrapolated to all drugs for which Medicare pays, the savings would have amounted to $667 million, the OIG asserts.

The report found that for some drugs, Medicare was paying up to ten times the average wholesale price offered by drug purchasing groups and wholesalers. For the overwhelming majority of drugs, Medicare was paying at least 20 percent more.

Because Medicare only pays for drugs which are used with DME or administered via infusion, the massive reductions which the OIG recommends in drug payments would especially impact infusion providers and nebulizer suppliers, according to industry analysts.

The OIG also complains that the Part B carriers, including the DMERCs, are inconsistent at setting drug reimbursement rates. The report found geographic variations in the amount paid for various drugs, as well as prices being updated on a yearly basis, instead of quarterly as the law allows. For some drugs, prices varied by up to 20 percent from one state to another, apparently because of lags in updating prices and differing interpretations of the statistics.

Apart from deeper cuts in drug payments, the OIG recommends trying a drug rebate program for Medicare similar to the one Medicaid uses, or competitive bidding for drugs.

Medicare's allowances for prescription drugs increased 25 percent from $1.8 billion in 1995 to $2.3 billion in 1996. At the same time, allowed services only increased 9 percent year-on-year.

With drugs such as albuterol and infusion drugs "there is a profit margin," notes **Tim Redmon** with the **National Community Pharmacists Association**. He adds that, after last year's small reduction, industry observers "at least suspected that somebody would come back for more cuts. That's exactly what's happening now."

HCFA Can Develop A Dispensing Fee

In addition to reducing the reimbursement for prescription drugs to 95 percent of average wholesale prices, the 1998 budget gave the **Health Care Financing Administration** the authority to develop a dispensing fee for those drugs, notes attorney **Alan Parver** with **Powell, Goldstein, Frazer and Murphy** in Washington, DC. That authority is "something we could certainly use to develop our educational efforts with HCFA," Parver notes.

Pharmacies, infusion providers and DME dealers need to teach HCFA more about what they do and what services they render, since Medicare currently does not pay at all for services in addition to drugs, Parver insists.

"It's unclear to me how, if an entity is paid its acquisition cost for a drug, it could possibly provide any services," Parver adds. "In the infusion area, that would probably make it very difficult for a pharmacy to provide any services."

In the past, Redmon claims, Medicare officials would argue that the service component was "built into the fee schedule" for prescription drugs. Now that this component may be removed, Medicare's insistence that it "won't pay for services" means that providers are left unable to service beneficiaries, he maintains.

The president's proposal may languish in Congress. "It's not at all clear whether there will be a Medicare bill this year," Parver notes. ◊

Hospice Care

HOSPICES UNDER FIRE FOR RELAXING INTERDISCIPLINARY TEAM MODEL OF CARE

If your hospice is not holding frequent interdisciplinary care team meetings, beware: the feds are training their sights on you.

While the **Health Care Financing Administration** so far mostly has cracked down on hospices in California for this compliance problem, hospices elsewhere would be wise to heed their warnings, industry veterans say.

The interdisciplinary care team model requires the patient's care to be equally coordinated by four core team members: a physician, nurse, medical social worker, and counselor. Auxiliary services such as pastoral care and a dietitian can be utilized as well.

According to the hospice conditions of participation, the interdisciplinary team should be "at the very core of how hospice is delivered," explains **Rigney Cunningham** of the **Hospice Federation of Massachusetts**.

However, many hospices nationwide are fail-